The Dream

A Psychodynamically Informative Instrument

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The dream is a unique psychodynamically informative instrument for evaluating the subjective correlates of brain activity during REM sleep. These include feelings, percepts, memories, wishes, fantasies, impulses, conflicts, and defenses, as well as images of self and others. Dream analysis can be used in a variety of clinical settings to assist in diagnostic assessment, psychodynamic formulation, evaluation of clinical change, and the management of medically ill patients. Dreams may serve as the initial indicators of transference, resistance, impending crisis, acting-out, conflict resolution, and decision-making. A clinically functional categorization of dreams can facilitate an understanding of psychopathology, psychodynamics, personality structure, and various components of the psychotherapeutic process. Examples of different types of dreams are provided to illustrate their relevance and use in various clinical situations.

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Unique among the medical and psychiatric treatment modalities, psychoanalysis and psychodynamically oriented psychotherapy do not make use of laboratory tests or measuring devices for diagnostic purposes. During the period described as the "decade of the brain,"[1] psychiatry began utilizing neuroimaging techniques and neuroendocrine measurements that have provided us with relevant information about brain functioning. Nevertheless, as exciting and informative as these neurobiological tests are, they remain within the realm of objective biological measurements of brain function and activity. As technologically sophisticated as we have become, we still lack a reliable measurement of self-experience; that is, a diagnostic instrument designed to assess the subjective correlates of brain activity, both conscious and unconscious. These correlates include feelings, percepts, memories, wishes, fantasies, conflicts, impulses, and defenses, as well as images of self and others.

Yet there does exist a time-tested psychodynamically informative instrument that I believe is as qualitatively reliable as any current psychometric evaluation, PET scan, or neurotransmitter measurement. I am referring to the dream, a singularly subjective mental experience that Freud[2] began investigating over a century ago in order to understand unconscious mentation.

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During the one hundred years since Freud published his original hypothesis, our understanding of the function of dreaming has changed significantly. Freud believed that the dream was a mental phenomenon designed to censor biological impulses and unconscious wishes in order to preserve sleep. Subsequent to Freud's observations, a multitude of sleep laboratory and clinical studies have suggested that the dream and/or REM sleep is an inborn biological phenomenon designed to facilitate memory processing, problem-solving, mood regulation, and psychological adaptability.[3–12]

Neurophysiological studies indicate that dreaming occurs when the brain is activated during REM sleep.[11,13,14] This consists of excitation of forebrain circuits due to activation of the pontine and midbrain reticular activating systems. In addition, there is selective activation of occipital, parietal, and limbic regions along with excitation of cholinergic neurons and inhibition of noradrenergic as well as serotonergic neurons.

Reiser[4] observes that current and past conflicts or problems, derived from memory, are reflected in dream images and are connected by similar affects. A number of investigators emphasize the adaptational, learning, and problem-solving functions of dreaming.[5–10] Koulack[5] points out that stressful experiences are incorporated into dream content in order to promote mastery. Greenberg and Pearlman's[9,10] research suggests that the manifest dream represents the dreamer's attempt to cope with meaningful issues and problems. Palombo[15] views REM sleep or dreaming as a vehicle for matching and storing recent memories with those from the past for the purpose of integration and adaptability. Kramer's[12] experiments indicate that dream content is linked to waking, pre-sleep emotional concerns and is predictive of the mood of the dreamer on the subsequent morning. A "successful" night's dreaming is the result of progressive-sequential emotional problem-solving throughout the night.

Although some argue that dream imagery is random and devoid of meaning,[11,13,14] the majority of investigators believe that dream content subserves important psychodynamic functions. Whereas Freud[2] concentrated his efforts on discovering the latent meaning and hidden impulses or wishes underlying the dream, contemporary analysts focus more on the manifest imagery and the metaphorical meanings contained within it.[16,17] To be sure, dream imagery often reflects impulses and wishes, as Freud observed, but it also conveys a spectrum of emotions, past experience, recent events, defensive operations, perceptions of self and others, conflicts, problems, and attempts at their resolution.

The time-honored approach to understanding the meaning of dreams has been through the use of free association, usually during therapy sessions. This remains the most productive method of comprehending the dreams of patients. However, in the current practice climate of managed care, with emphasis on time-limited therapy and psychopharmacologic intervention, we often do not have the leisure of analyzing our patients' free associations in the absence of a time constraint. Moreover, an increasing number of psychodynamically oriented psychiatrists work in diverse clinical settings, including emergency departments, inpatient units, outpatient clinics, consultation-liaison services, and partial-hospitalization programs. As a consequence, clinicians are often required to evaluate and diagnose patients over a briefer time span than previously allowed.

Although careful history-taking and assessment of mental status remain the foundations of clinical evaluation, dream material may provide additional information and insight into the patient's psychodynamic and diagnostic status. For example, dreams may serve as early warning signals of suicidality, homicidality, ego-disintegration, psychosis, and impending acting-out behavior. Manifest and latent content may lead toward a particular diagnosis when conscious symptoms and behavior seem confusing or ambiguous. The presence of an affective disorder or emotional dysfunction may initially be manifested in dream material. Medically ill patients can be managed and treated in a more informed way through an understanding of the hopes, fears, and beliefs connected to their illnesses as reflected in dream imagery. For psychiatrists who work in outpatient and inpatient settings, dream material may indicate clinical improvement or regression. Transference reactions are sometimes initially presented in dreams prior to their conscious expression. Likewise, countertransference may first become evident in the dreams of the therapist, informing him or her of unrecognized feelings and attitudes toward the patient. The salient psychodynamics underlying therapeutic impasses and persistent resistance may also be reflected in dream material. Often, the initial indication of a significant decision, change toward healthier behavior, or readiness to terminate treatment may be signaled in dreams. In addition, conflict resolution and solutions to problems are frequently previewed in dreams. Thus, dreams provide

useful information throughout the entire spectrum of clinical activity. In a broad sense, the dream can be viewed as a psychodynamically and psychodiagnostically informative instrument.

In order to be more rapidly understood, dreams require an active process of free association on the part of both patient and therapist. This entails a collaborative effort whereby therapist and patient work cooperatively in arriving at a mutual understanding of the dream. This approach contrasts somewhat with the classical model, where the patient free-associates while the analyst usually listens passively, and subsequently interprets the dream.

In the free association model I am describing, the therapist uses the patient's associations, as well as his or her own associations and knowledge of the patient, in order to intervene more actively with questions, observations, and trial interpretations. In my experience, patients can be oriented to this process rather quickly, provided that they possess some measure of intelligence, imagination, and psychological-mindedness. If the dream is experienced by the patient as his or her own unique creation that can be understood by means of an active dialogue, its meaning usually has greater impact than if it is viewed as a mysterious occurrence to be analyzed by an outside observer. Moreover, the patient's active participation in the process of understanding the dream empowers him or her to make choices, change behavior, or take action based on the dream's meaning. This can be particularly helpful in settings where contact with the patient is brief in duration (e.g., consultations). Likewise, information from dreams can help the clinician formulate opinions and arrive at decisions in a more expedient fashion (e.g., pharmacological intervention, hospitalization). Because the patient is an active collaborator in this endeavor, there is a greater likelihood of compliance regarding decisions growing out of dream analysis (e.g., beginning medication).

From a psychodynamically functional viewpoint, dreams can be classified according to the following types:

1. Presenting conflict-issue.
2. Impending crisis.
3. Psychodynamic-diagnostic.
4. Affective state.
5. Self-representational.
6. Relational-transferential.
7. Resistant-defensive.
8. Problem-solving, decision-making.

These categories are constructed arbitrarily, but I find that they can be useful from a functional and clinical point of view. Recognizing that one or more of these elements is present in every dream, I nevertheless have observed that a central psychodynamic theme or function is often embedded in each dream. In effect, this classification can provide the clinician with a framework aimed at organizing the data from dreams that is relevant to the various components of the psychotherapeutic process. The following examples illustrate these different types of dreams and their application in the clinical setting.

CASE EXAMPLES

1. Presenting Conflict-Issue: A 40-year-old married woman entered treatment with feelings of anxiety and inadequacy, especially at work and in social situations. She was obsessed with her physical appearance and worried that her husband might have an affair. She reported the following dream in her first therapy session: "I was at a concert where a woman conductor was leading an all-female chorus. My husband was in the audience and I looked for his secretary in the chorus. Then I realized the conductor was myself." With little encouragement, the patient talked about her interest in music and singing. However, her older sister was more talented musically and obtained better grades in school. Her father often commented that the patient had "the looks" in the family, but that her sister had "the brains." Throughout her childhood and as an adult, she competed with her sister for her father's attention and compliments. At work and in social gatherings, she constantly compared herself with other women in regard to her intelligence and attractiveness. She was particularly threatened by her husband's relationships with other women, especially his secretary. By the end of the session, the patient more fully appreciated her excessive need to dominate and compete with other women, especially in the presence of men.

2. Impending Crisis: A 35-year-old married woman was in treatment for recurrent depression, self-mutilating behavior (cutting her arms), and several suicide attempts. A major psychodynamic theme was her need for self-punishment because of her past history of promiscuous behavior and multiple abortions. She often experienced terrifying feelings of aloneness and inner emptiness. Over the course of several sessions, she reported the following recurrent dream: "I'm in an ocean with giant waves, and I'm trying to cling to some rocks. I see you in a rowboat with your hand outstretched, but I cannot grab hold of it and you cannot reach me. My hands keep slipping off the rocks and I'm afraid I'll

let go and drown." Each time the patient had this dream, the waves grew larger and her hold on the rocks became more tenuous. She associated the power and intensity of the waves to her suicidal impulses and the rage she felt toward herself. Her loosening grasp of the rocks was connected to her diminishing capacity to control her suicidal impulses. Finding herself alone in the ocean and lacking the strength to save herself reminded her of her sense of inner aloneness and emotional fragility. Although she believed I was trying to help her, nothing I said or did seemed to be effective. I finally hospitalized her when she could no longer hold onto the rocks in the last dream of this particular sequence.

3. Psychodynamic-Diagnostic: A 30-year-old single man was referred by his family physician with a history of tachycardia, palpitations, and atypical pain in his left arm and precordium. A complete physical workup, including a cardiac evaluation, was normal. In his first session, he reported the following repetitive dream: "I've killed somebody, but nobody knows I did it. I feel very guilty and am afraid of being found out." The patient had recently joined his father's professional firm with the understanding that he would eventually take it over. However, his father had a partner, and the patient had been concerned about the partner's feelings regarding his entering the firm. Approximately six months prior to his joining them, the partner had a sudden heart attack and died. In discussing his feelings about the partner's death, the patient revealed that he had harbored conscious death wishes toward the partner as a solution to the problem. Soon after the partner died, the patient developed his somatic symptoms and became convinced that he had a heart problem and might die. Over the course of succeeding sessions, we became aware of the connection between the patient's guilt over his homicidal fantasies and his fear of retribution in the form of a heart attack. His cardiac symptoms were clearly a somatization of this conflict. The diagnosis of an anxiety disorder with conversion features appeared validated by the psychodynamic factors that emerged from the dream content.

4. Affective State: A 40-year-old married woman was attempting to cope with various stressors, including her 9-year-old daughter's brain tumor, a difficult supervisor at work, and her husband's lack of emotional sensitivity. She reported the following dream: "I was swimming up a hill of water, and it was very icy. My daughter was swimming with me, but she slipped under the water and I couldn't find her. I finally reached her and pulled her up. I was terrified." The patient associated to the terror she felt in connection with her daughter's brain tumor. It had been successfully removed, but she knew the possibility of a recurrence existed. Her daughter was scheduled to have a follow-up MRI, and the patient was terrified that evidence of a recurrence would be found. She felt her life was an uphill battle in which she was struggling with her daughter's illness, her husband's emotional remoteness, and her supervisor's lack of support. The icy water reminded her of the emotional coldness she experienced with her husband and her supervisor. It also conveyed her inner sense of extreme isolation and loneliness.

5. Self-Representational: A 38-year-old married woman was suffering from the complications of radiation treatment for a malignancy. Although her malignancy was in remission, she felt despondent because the side effects of the radiation (pain, nausea, fatigue) were unrelenting. She believed that she was going to die prematurely, and worried about the well-being of her husband and children after her death. She reported the following dream: "I was in the hospital dying of metastatic disease. A lot of my friends were there and they were very upset, but I wasn't. I kept telling them about what's meaningful in life—things like love and peace. My doctor came in and I asked him to take my hand and stay with me until I died. He did, and I knew I was going to die, but I felt content and at peace." The patient was hoping that she would die in order to avoid living with the complications of the radiation. She was in constant fear of developing recurrent disease and felt that no one could understand what she was experiencing. At the time of this dream, she had made up her mind to kill herself. The fact that I was the only person to whom she could entrust these thoughts and feelings made her feel more comfortable and reconciled to her impending death. In this sense, the dream reflected her positive transference and a trusting therapeutic relationship.

6. Relational-Transferential: A 43-year-old married man was in treatment for inability to control his anger. He had a history of alienating friends, family members, and colleagues at work. He viewed himself as ineffective and a failure in his career. His father was extremely critical and demeaning of him during his childhood, and the patient felt that he neither loved nor cared about him. During therapy, the patient became increasingly insistent that I cure him of his anger and feelings of inadequacy. He related the following dream: "I went to my friend Mike's office to ask him for help. I looked out the window and saw a man get into my car and drive it around until he smashed into a wall. I ran out and asked him what he was doing. He replied that he was trying to park the car and it wasn't his fault. I returned to Mike's office, but he was gone." The patient felt that the car represented his life—emotionally abused by his father and littered with wrecked relationships as well as career failures. Smashing up the car reminded him of the uncontrollable rages that played a significant role in the rupture of past relationships. His friend's disappearance, as well as the man who smashed up the car and refused to take blame, reflected both his father and myself. He felt that I was unconcerned and uncommitted in the effort to understand and control his anger. Moreover, he believed that I was dishonest and disingenuous in my statements and actions. Not surprisingly, the patient left treatment soon after having this dream.

7. Resistant-Defensive: A 28-year-old single man entered

treatment with a history of poor motivation, procrastination, and self-sabotaging behavior. Although he was extremely intelligent and held an advanced degree, his career was at a standstill and he felt paralyzed in his attempts to change it. Despite our discovery of some of the sources of his self-destructive behavior, he remained at a therapeutic impasse. Approximately two years into treatment, he told me the following dream: "I hired someone to kill me for $7,000. I knew that I could call off my own murder at any time, but then I would lose my money. I finally called it off and lost my money."

The dream occurred just before the patient's 30th birthday. He had resolved to make a significant change in his life by the time he was 30. The $7,000 was the amount of money he had paid me over the prior two years. Essentially, he had hired me to "kill off" the part of himself that was self-defeating, but he resented paying for it. Over the course of the previous two years he had failed to change, and he felt that he had wasted his money. On the other hand, murdering himself symbolized his self-destructive behavior that he hoped to change through therapy.

8. Problem-Solving, Decision-Making: A 39-year-old divorced woman was in treatment for depression, bulimia, and obesity. She was an executive in a corporation that was downsizing, and her responsibilities kept increasing as her colleagues were leaving. She was also in a relationship with an older married man. He provided her with emotional support, but the time they spent together was limited, which resulted in the patient feeling unfulfilled and dissatisfied. In this context, she reported the following dream: "I was on a bus in California that was traveling eastward. I knew I was going in the wrong direction but felt helpless, and that my destiny was out of my control. Somehow, I got off, rented a car, and headed west." The patient associated the busload of people to fellow employees who were taking early retirement, including her boyfriend. She was unable to do likewise because she had to raise and support her young son. She also realized that her relationship was unsatisfactory, and deliberated over accepting a date with another single man who had expressed an interest in her. She had lived in California following her divorce, and recalled it as a time when she felt happy and independent. In addition, she was gaining weight and knew that she had to begin dieting in a more serious way. Shortly after having this dream, the patient broke up with her boyfriend and began a relationship with the other man. She remained at her job and began losing weight.

DISCUSSION

These clinical vignettes illustrate how dreams can facilitate an understanding of various aspects of our work with patients. Similar to other diagnostic and projective tests, they can be extremely informative if used judiciously in the context of the entire clinical situation. In Example 1, the patient's dream highlighted her central conflict and led us to a significant etiological component of it (e.g., sibling rivalry). This was the first dream she reported, and in addition to shedding light on the determinants of her conflict, it also revealed some of the defensive maneuvers she employed (attention-seeking, controlling behavior). This dream, like many other first or initial dreams reported in therapy, was instrumental in paving the way to an understanding of the patient's central conflict, defenses, self-representation, and interpersonal relationships.[18]

The dream in Example 2 dramatically portrayed the progressive self-disintegration of the patient and clearly signaled her impending suicide. The manifest content provided a metaphorical presentation of the patient's losing struggle against her self-directed rage and inner helplessness. The vivid portrayal of the patient's feelings and her self-perception in the manifest content demonstrate that manifest imagery is not always a censorship process requiring laborious deciphering. In this case, it presented as a thinly disguised pictorial sequence requiring translation into a meaningful story. The nature of the transference was also reflected in graphic, undisguised imagery (i.e., my helpfulness was ineffectual).

The dream in Example 3 communicated the patient's central psychodynamic conflict, subsequently leading to a definitive diagnosis. Frequently, dreams metaphorically portray a patient's physical or psychiatric illness. For example, an 83-year-old man dreamed that he was planning a trip. However, he was unable to find his belongings that were to be packed, and then lost his way while driving. He awakened feeling confused, lost, and frustrated. The patient was originally referred for repetitive nightmares and declining memory. An MRI and psychometric testing revealed dementia secondary to multi-infarct disease. Another patient, a middle-aged woman with vague, puzzling somatic symptoms, dreamed that she was walking up a steep hill with great difficulty. This dream helped to establish a diagnosis of major depression. According to Fiss,[19] dreams are sensitive to subliminal physical stimuli and may serve as early detectors of somatic illness. Freud[2] made the same observation when he noted that "disorders of the internal organs obviously act as instigators of dreams." (p. 34).

The dream in Example 4 reflected how feelings are manifested both overtly and symbolically in dream con-

tent. The affective component of dreams is of major importance because the patient is not always consciously aware of feelings. Kramer's[12] selective mood-regulatory theory of dreaming suggests that an important function of dreaming is to contain the affective surge that occurs during REM sleep. According to Kramer, if the dream is successful in processing the emotional concerns of the dreamer, the latter has no memory for dreaming. Partially successful or unsuccessful processing of emotions leads to disturbing dreams or nightmares. Moreover, the mood of the dreamer on the following morning is connected to the successful or unsuccessful processing of emotions during the night. Bonime[20] observes that feelings in dreams are either experiential or symbolic. In Example 4, the patient experienced terror directly in her dream. However, her feelings of emotional isolation and loneliness were represented symbolically by the icy water. Although Freud[2] believed that affect was generally suppressed in dreams by means of the dreamwork, he also observed that intense affect may be directly expressed in dreams. Lack of feeling in dreams is an equally important finding and may indicate repressive or dissociative defenses as well as alexithymia. Exploration of the presence, absence, and quality of feelings in dreams may lead to a wealth of information about the patient's diagnosis, dynamics, sense of self, and defensive style.

The dream in Example 5 validated the patient's conscious communications about her self-experience. In addition, it alerted us regarding her impending decision to commit suicide. This patient viewed herself as irreversibly damaged and on a trajectory toward an early death. Although she reported conscious feelings of fear and hopelessness, the mood in her dream was one of contentment. Her sense of resolve about dying was an important clue to her suicidal intent. The dream also indicated a strong element of trust in the transference. This was validated by the patient's assertion that I was the only person with whom she felt comfortable enough to share her feelings. Self-representational or self-state dreams reflect various aspects of a patient's self-function, including body image, physical attributes, character traits, feelings, values, hopes, and ideals.[21] Similar to this patient's dream, they may also include transferential, conflictual, and problem-solving elements.

The dream in Example 6 had been preceded by several weeks of complaints by the patient that his progress was too slow. Others, including his wife, experienced him as angry, critical, and intimidating. From the patient's perspective, the men in the dream displayed qualities of his father and myself, indicating the transferential aspects of the dream. His father was critical and insensitive and had emotionally abandoned the patient. He felt that I was indifferent, untrustworthy, and not competent enough to help him. The dream also reflected the patient's projected feelings of rage, helplessness, and abrogation of responsibility. Transference dreams often occur well before a patient consciously expresses either positive or negative feelings toward the therapist. Not only can they make the therapist aware of unspoken attitudes and feelings, but they can also serve as dramatic illustrations for the patient of distorted perceptions of others.

The patient in Example 7 resisted change by means of avoidance, procrastination, and indecisiveness. He was unwilling to take risks in his career and relationships, fearing rejection or failure. The extent to which he engaged in self-sabotaging behavior was characterized in the dream by his willingness to lose $7,000 in order to avoid change. The patient also had a repetitive dream in which he found himself in a plane taxiing down the runway but unable to take off. We often used the imagery in these dreams as our private code or reference to instances of his self-destructive behavior. I find that such references to dream imagery can be helpful in promoting a patient's awareness of specific character traits, conflicts, and defenses. For example, we frequently referred to the image of the plane sitting on the runway and unable to take off whenever the patient engaged in self-paralyzing behavior. For him, self-defeating thinking and behavior were often synonymous with resistance. As an example, he continuously delayed writing an article for publication and kept forgetting to show it to me as he had promised.

Example 8 demonstrates the problem-solving function of dreaming. The bus heading in the wrong direction symbolized the major issues with which the patient was struggling, including the demands of her job and her unfulfilling relationship. However, she was able to overcome her helplessness, make a decision, and take action (getting off the bus and renting a car in order to travel in the right direction). Greenberg and Pearlman's studies, in particular, have suggested that dreams facilitate learning and problem-solving.[9,10] Palombo[15] observed that dreaming provides an opportunity to store recent memories by matching them with past memories as part of a problem-solving, adaptive process. In this

dream, the patient's current feelings of conflict and helplessness were juxtaposed with her sense of effectiveness and independence when she lived in California. The solution to her dilemma in the dream was predictive of her subsequent decisions regarding her job, boyfriend, and diet. Decision-making dreams can be informative regarding imminent constructive changes, or they may indicate impending acting-out, resistance, and premature termination (Example 6).

I have attempted to demonstrate by means of these clinical examples how the dream can be effectively employed as a psychodynamically and psychodiagnostically useful instrument. Although I have arbitrarily classified dreams into eight discrete categories, I recognize that most dreams contain one or more of these psychodynamic elements. Basically, this classification is a way of structuring and understanding dreams in a clinically pragmatic fashion. Frequently, dreams may validate the known clinical data; at other times, they are the first indicators of central conflicts, impending decisions, transference reactions, or suicidal impulses. Successive dreams over the course of long-term treatment may also be used to validate and facilitate clinical change in regard to core conflicts, transference, resistance, self-representation, and interpersonal relationships.[22] However, the clinical application of dream material need not be limited to long-term psychoanalytic treatment; this material may also be used in a variety of clinical encounters, including single consultations and time-limited therapy.

Dreaming is a uniquely personal, creative phenomenon. It is a profoundly subjective experience that patients can acknowledge and value as a deeply meaningful communication within themselves. Frequently, patients dismiss or minimize a dream by commenting: "it's only a dream," as though it were not something "real." I respond by saying that the imagery in dreaming is as "real" and tangible as any waking thought or feeling. In addition, I explain that dreams constitute our subjective perception of brain activity during sleep.

Most patients can be taught how to process their dreams through free association without necessarily struggling to discover an underlying, esoteric meaning. The key lies in appreciating the symbolic message conveyed by the manifest imagery. Rather than always camouflaging an obscure wish or conflict, the manifest imagery often informs us metaphorically about the central problem or clinical issue. In fact, the manifest content itself has been the focus of investigation regarding childhood traumatic experiences, assessment of ego function, and the quantification of hostility in hypertensive and normotensive patients.[23–25] Nevertheless, I do not wish to minimize the importance of latent content, nor the fact that significant psychodynamic elements are invariably embedded in manifest imagery.

The essential point for patients is to appreciate the meaningfulness of their dreams and to realize that they are quite capable of understanding them. For therapists, it is important to keep in mind the spectrum of psychodynamic information provided by dreams in connection with conflicts, problems, feelings, relationships, transference, resistance, self-image and decision-making. In referring to the dream as a psychodynamically informative instrument, I am essentially paraphrasing what Freud[2] so presciently observed one hundred years ago: "By analyzing dreams we can take a step forward in our understanding of the composition of that most marvelous and most mysterious of all instruments" (page 608).

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